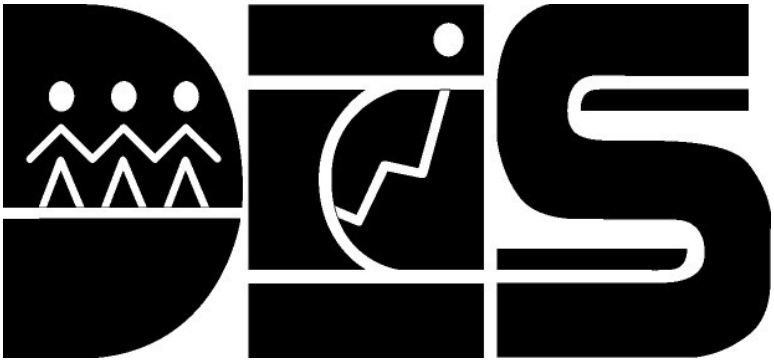

Department of Economic Security
Division of Children, Youth and Families

Arizona Case Review Report
November 2007

Table of Contents

Foreword …… i

Arizona Case Review Report ……... 1

DES Response ……. 22

Department of Economic Security
Division of Children, Youth and Families

Arizona Case Review Report
FOREWORD

As part of its on-going self-assessment, in June 2007 the Department of Economic Security – Division of Children, Youth and Families (DES-DCYF) requested that national expert Wayne Holder, MSW, from ACTION for Child Protection, review two child welfare cases involving Brandon Williams and siblings Tyler and Ariana Payne.[1] The Division sought this review in order to obtain an independent evaluation of the casework and decision-making in those cases with emphasis on: identifying areas of case strength, identifying areas needing improvement, and considering a comparison of casework in these cases to national child welfare best practice. Mr. Holder's review and recommendations were provided to the Division in his *Arizona Case Review* report. The Division appreciates Mr. Holder's thoughtful analysis and recommendations, which confirm the direction and appropriateness of child welfare practice improvements the Division has recently implemented.

In his case review report, Mr. Holder acknowledged that the Division was already in the process of taking corrective action to address identified practice improvement concerns. He noted that "these actions, in general, direct implementation of a guided approach to safety assessment, strengths and risk assessment and case planning that gives purpose and meaning to information, identifies information necessary to make sound decisions and provides a template format to guide information collection and integrate case information in a meaningful and logical way. Arizona has invested significant time and effort into this process in order to improve practice across the state." This document addresses each of Mr. Holder's recommendations and identifies the specific practice improvements already implemented by the Division that address the recommendations and reflect the Department's continued commitment to improving child welfare practice in Arizona.

Background on Arizona Child Welfare Practice Improvements

The Department's response to Mr. Holder's recommendations focuses extensively on the revised, comprehensive child safety assessment/case planning process implemented by the Division between January and June 2007. However, it is important to recognize that this was the latest step in a continuous improvement process initiated in 2003 to transform child welfare practice in Arizona from an incident-based practice – where investigations and on-going case management were focused almost exclusively on the specific report allegations and the family's current status – to a more holistic model that

[1] This process included a review of the paper case file only. As noted on Page 1 of Mr. Holder's *Arizona Case Review*, "It is important to state that these records were reviewed independently. That is, no information from staff was received other than that contained in the case file. Therefore, issues related to staffing, organizational capacity at the time, or other issues that may affect practice were not reviewed."

is focused on a comprehensive assessment of the family's functioning – past and present – and case planning that is inclusive of the family and is focused on specific behavioral changes required of the family to improve the child's safety and the family's overall well-being.

The practice improvement process began with the Division's November 2003 implementation of an enhanced Child Safety Assessment and the January 2004 implementation of an improved Family-Centered Strengths and Risk Assessment. In addition to conducting random case reviews in each District, the quality assurance process for the implementation of those tools included an external, independent review of their effectiveness to be conducted one year after implementation.

In the meantime, the Division implemented interim practice improvement strategies, including hands-on training for all CPS supervisors on critical decision-making regarding child safety throughout the life of a case. The supervisor training included information about the case-specific information needed to make critical decisions about child safety, how to assess the information collected; how to evaluate their staff's decisions about child safety; and, how to help build critical decision-making skills within their staff.

The Division also contracted with Arizona State University to develop and provide training to CPS supervisors on facilitating "Supervision Circles," groups of CPS Supervisors who meet on an ongoing basis and review cases to discuss and obtain the expertise of their peers in assessing the quality of decisions made by their staff. Supervisors then share their peers' insights with local staff to build on individual staff strengths and improve their individual practices.

In late 2005 and early 2006, the independent quality assurance review to gauge the practical application of the Child Safety Assessment and Family-Centered Strengths and Risk Assessment was conducted through technical assistance from the National Resource Center for Child Protective Services and the National Resource Center for Family-Centered Practice and Permanency Planning. This technical assistance included a review of child welfare policies and procedures, review of case records, facilitation of staff focus groups, observations of training delivered to CPS specialists in two sites, and a comprehensive review of relevant training materials. The evaluation report – received in May 2006 - concluded that there were inconsistencies in: staff's application of child welfare policies and procedures regarding child safety assessments and family strengths and risk assessments; staff's understanding of the steps required to assess child safety and to develop, implement and monitor sufficient safety plans; and, the supervision staff were receiving in completing critical job functions, such as assessment of child safety, risk of harm, and family needs, as well as case planning.

To address these critical child welfare practice improvement issues, a Division workgroup – with assistance from the National Resource Centers – developed a comprehensive process for child safety assessment, family strengths assessment, risk assessment, and case planning that was scheduled to be implemented once an automated version was ready. The automated version is on schedule and will be launched in November.

Urgency in Implementing Additional Child Welfare Practice Improvements

In November 2006, Kenneth Deibert joined DES as Deputy Director for the Division of Children, Youth and Families. After discussing the Division's performance with central office administrators, conducting detailed case reviews and engaging field staff and supervisors in open dialogue about their front-line work with families, Deibert decided that the needs of Arizona's children and families would not wait for technology, so a paper version of the comprehensive process for child safety assessment, family strengths assessment, risk assessment, and case planning was implemented from January through June 2007, *10 months ahead of schedule.*

The enhanced process guides case managers in the collection and analysis of information about the family and its dynamics. It also guides the case manager's decision-making based on that information, including building a case plan with the family that is focused on specific outcomes.

The Division leadership is closely monitoring the implementation of the comprehensive process for child safety assessment, family strengths assessment, risk assessment, and case planning by conducting random case reviews in each District. The outcomes of the reviews will inform the Division of any additional training and technical assistance that staff and supervisors statewide or in particular geographic areas may require as they embed this improved process in their child welfare practice.

Pages 1 through 21 of this document include Mr. Holder's review and analysis of the cases and his recommendations. Pages 22 through 29 of this document include a list of those recommendations, and demonstrate how recent improvements in Arizona's child welfare practice are addressing those recommendations

ARIZONA CASE REVIEW

Wayne Holder, MSW
Executive Director
ACTION for Child Protection

September 2007

Purpose of Review

In response to a request from the state of Arizona, two cases involving recent child fatalities were reviewed. The stated purpose of this case record review was to evaluate casework and decision making in order to:

- Identify areas of case strength
- Identify areas needing improvement
- Consider comparison of casework in cases to state of the art or a best practice perspective

It is important to state that these records were reviewed independently. That is, no information from staff was received other than that contained in the case file. Therefore, issues related to staffing, organizational capability at the time, or any other issues that may affect practice were not reviewed.

This report is structured as follows:

1. Overview/summary of each case.
2. Observations regarding strengths in case practice for each case.
3. Observations regarding areas for practice improvement for each case.
4. Observations on case documentation for both cases.
5. Comparison of casework in cases to state of the art or a best practice perspective.
6. Recommendations based on case reviews.
7. Closing.

1. Overview/summary of Marsh/Williams Case

This is a highly complex, challenging case. In addition to substance abuse (which was referred to one time with no elaboration) this case contained every serious problem faced by CPS: violence; serious adult mental health and general functioning problems and limitations; cognitive disabilities; conflicted adult relationships; ineffective and non protective parenting; parent–child conflict and detachment; extreme developmental limitations and emotional disturbance in all the children; alternating and sometimes exaggerated stress accompanied by periodic crises; financial difficulties; housing problems; physical abuse; and serious and chronic neglect. Mentioning the magnitude of the conditions that prevailed in this family for 14+ years establishes an important perspective. The very best intervention and intervention circumstances could very well not have succeeded in strengthening the Marsh/Williams family to achieve success and to exist independently from CPS as an intact family capable of assuming protective roles with the children on its own.

Notably, the case record fully demonstrates a long and continuing significant commitment of the community to this family. The involvement of CPS and a range of community service providers remained almost constant following the original case identification. Substantial evaluation, treatment, medical and education services were applied to this case in daily, weekly and monthly amounts. As a highly visible family, the community responsibly reported concerns for maltreatment routinely. CPS responded usually ruling out maltreatment but eventually providing case management services that attempted to orchestrate all the persons and activities that were deemed necessary to treat this family. Since 1993, community services particularly directed at the children occurred without interruption apparently even when there was no open CPS case. There is no question that the community assumed a great deal of responsibility to assist and support this family and

expended considerable effort and resources in doing so. Six or so years after the family became known to CPS, a report of physical abuse was substantiated and the case remained open. The same kind of community activity and involvement continued at that time, however, CPS began to provide case management and acted, in so far as the record can be interpreted, as coordinator of decision making and service provision. September 1, 2006 to March 22, 2007 reflects the period of time when the mother and Brandon dropped out of sight. The CPS issue at this time is clearly safety. In fact it was a present danger situation. This period was proceeded by indications of an ambivalent mother struggling with relinquishment of her older children. The record indicates (without qualification) that she was overwhelmed. In September the mother was in a crisis related to [redacted] The first specific indictor of disintegration seems to appear in mid September with the knowledge that the mother who had maintained a residence since 1993 was residing in a motel. The mother had obviously gone underground since she was not responding to everyone's attempts to reach her and no one had encountered her; knew of her circumstances; or knew where to find her. The situation was exacerbated by Brandon's functioning which notably was similar if not the same as [redacted] when he was Brandon's age. The record was clear for years about the mother's inabilities to care for and protect her children and about her insecurities as a parent. Buried deep in the record were indications of the mother's [redacted]

Present danger exists when the whereabouts of a reported vulnerable child or a vulnerable child in an open case are unknown. Present danger requires immediate action to create a sufficient protective measure. Whether CPS demonstrated sufficient efforts to locate the mother is a question for the agency given the context of present danger. The record indicates that a supervisor and the worker acknowledged the gravity of the situation. It isn't clear whether the record documents all the efforts expended to locate the mother and child.

2. Observations regarding strengths in case practice in the Marsh/Williams Case

- The level of effort and responsiveness of CPS was notable throughout the record is impressive. For the most part, CPS seemed to respond to reports within acceptable time limits; interviewed parents and children; and communicated with collateral information sources. Subsequent to 1999 as the case remained open, (without a careful tabulation), it appeared as though the level of worker activity with respect to contact with the children; contact and communication with the mother; and contact and communication with service providers was abundant.

- The attitudes and interactions with all family members was good. Worker – client interaction as reported or implied always seemed appropriate. The record reflects workers behaving with empathy, understanding and support for all family members. In particular, it appeared that workers were highly committed to helping this family and to understanding and being supportive of the mother.

- The case management related to addressing family and case situations; resolving various challenging situations and case problems; managing and supporting involvement of service providers; and managing placements was good. Worker–provider interaction was appropriate and effective. Workers were highly responsive to providers related to communication and involvement in case matters. Workers convened and included providers in evaluating and planning.

- Record keeping regarding the day to day process of case circumstances and worker and service activity was evidenced through supervisory involvement with respect to specifically mentioned worker–supervisor consultation and by indication of supervisor approval for worker actions and decisions.

3. Observations regarding areas for practice improvement in the Marsh/Williams Case

- Investigations were all allegation/incident based in so far as documentation revealed. The record identifies repeated referrals to CPS which resulted mostly in unsubstantiated findings and either referral for services; encouragement for parents to follow up with services; or no offer of services. All of the investigations as reflected in documentation, even through 2006, were almost exclusively focused on the allegation. When pertinent family information was identified, such as the mother feels overwhelmed, it was not explained or factored into the decision making process. Investigations did not take into account the family as a system and therefore did not consider family information collection directed to understanding presenting problems beyond what is symptomatically related to the existence of (substantiated) maltreatment. In effect, through the years, this allegation orientation resulted in not discovering the insidious nature of individual and family functioning and the context to fully understand dynamics associated with child safety. The work of many CPS staff resulted in an accumulation of information about the family that generally was not used to further understand family circumstances and for charting a course of action with this family.

- The record does not reflect that CPS assumed a clear role and responsibility for case leadership and governance. This refers to CPS expressing its authority to assure a specific course of action directed toward a specific planned outcome. The record doesn't reflect the reason for CPS involvement and doesn't demonstrate that clear identified objectives existed about what must change related to the mother's parenting and protectiveness. In terms of the reason for CPS, some might believe that the reason was to provide services to the children. Wasn't the reason for CPS involvement because the mother could not care for and protect her children? Despite the abundance of services that were

provided, there is no precise identification of what those services were to produce related to what must change for the mother to parent effectively and be protective.

- The mother's functioning and capacity was not effectively confronted. Throughout the case little focused assessment occurred concerning the mother despite references made which characterized her as [redacted] Furthermore, the information identified about the mother here and there throughout the record was never synthesized to create a growing picture and fuller understanding of her.

- No case plan assessments of the mother were in the record including in 2006. It is unclear how decisions were made in terms of case planning. The first structured (formatted) case plan found in the record appeared in September 2006. (Since services had been provided to family members including the mother since 1999 workers would likely argue that case plans did exist. However, before 9/2006, the record did not contain any document that identified goals, related services, benchmarks for change, tasks, assignments and time lines.) The primary objective of the 9/2006 case plan was reunification. (At the time the two older boys were placed.) A second structured case plan occurred in the record in December 2006. The primary objective of the December case plan was long term foster care. Both plans contained the same exact content (i.e. who the responsible parties were, what the outcomes were, the identified tasks, and various explanations.) Given entirely different case plan objectives with the same case plan content, what seems evident is that the case plans were not particularly influential in decision making about intervention with the family.

- These case plans were worker or CPS oriented and there is no indication that the mother was involved in the planning. There are a number of

traditional case plan principles that appear to be lacking in these case plans. Goals (referred to as outcomes in the format) were not specifically stated; were not behaviorally stated; were not measurable; were not mutually agreed to; were not tied to a realistic time line; and did not contain services related to the goals (outcomes).

- Safety intervention is generally lacking as a focused worker activity for the case in general. Of course safety intervention was not a formal model existing in Arizona during the early years of this case. The first safety assessment in the record is 9/1/2006. A comprehensive review of this safety assessment indicates that it was incorrectly completed and reflects a lack of understanding of the safety assessment process.

- The record contains a great deal of information about the mother related to safety assessment albeit the information is interspersed throughout the record. However, there is no indication that the information was used to inform safety decision making. Information within the record suggests or supports the following safety threats in this case related to the mother at one time or another:
    - Lack of supervision
    - Child is fearful of the mother
    - Behavior of [redacted] provokes the mother
    - Mothers behavior is violent
    - Mothers behavior is out of control
    - Mother refuses access; child's whereabouts unknown
    - Mother cannot or will not protect a child
    - Mother is unwilling or unable to meet child's immediate needs
    - Physical conditions of the home threaten safety
    - [redacted]

It should be clear that possibly or very likely all or most of these safety threats were not apparent or active when the safety assessment was

completed in September 2006. The point, however, is that some reconciliation of family context; family circumstances; and the mother's previous and current functioning would have provided valuable information to inform safety decision making. Throughout the case it is evident that whether the mother was a direct threat to her children or not, she was seldom, if ever, willing or able to be protective.

- The reason that CPS was/has been involved with the family is not clear and precise. The record is highly focused on the developmental delays and aberrant behavior of the children, in particular [redacted] The orientation of intervention was always associated with understanding; controlling; and enhancing the children's development and behavior, in particular [redacted] CPS always appeared to relate to the mother with respect to providing her services and support primarily related to managing the children's behavior. The range of services was considerable and did include mental health services for her. Services directed at the mother personally seemed to be related to building her capacity to manage the children. In terms of the reason for CPS, some might believe that the reason was to provide services to the children. Wasn't the reason for CPS involvement because the mother could not care for and protect her children? To elaborate, wasn't the reason for CPS involvement because the mother could not act independently and couldn't effectively perform her parenting roles and responsibilities without outside (CPS) influence? If this reason had ruled intervention, casework and the record likely would have given more emphasis to evaluating her needs and capacities related to parenting and protectiveness and time limited case plans would have been established with her to reduce limitations and enhance abilities.

- There was no progressive intervention process apparent in the case that was on a course to anticipated options based on how the family – the mother in particular – was responding and changing. CPS has three intervention options with cases: 1) close cases successfully based family/case achievement; 2) close cases unsuccessfully based upon

family/case not achieving but no CPS jurisdiction; 3) seek permanency alternatives for child separate from family because family/case not achieving but CPS has jurisdiction. The record doesn't' reveal a deliberate case process characterized by problem identification (reason for CPS); problem analysis (mom's needs and capacities related to reason for CPS); time limited case plans (concerned with reason for CPS and what mom must change); and behavior and progress measurement.

1. **Overview/summary of the Payne Case**

Federal leadership has been emphasizing the importance of comprehensive family assessment that effectively connects all the assessment methods and decision making events into a systematic framework directed at case outcomes. This case, like the Marsh/Williams case, serves as an example as to why that position is so crucial to effective CPS intervention. There were several opportunities to effectively assess family members in this case and to interpret the meaning of those assessments in ways to direct CPS intervention. Instead, the record indicates that each opportunity associated with CPS reports was totally focused on reconciling the allegation/incident.

Through these various opportunities to evaluate and understand this family, specific and concerning "pieces" of information were recorded but left unanalyzed. The mother was described across time as having feelings about intentions to hurt her children; having post partum depression; being bi-polar; having to have been hospitalized for mental heath reasons; having her ability to care for her children being brought into question by two fathers; allowing or acquiescing for three of her children to be taken by their fathers; and using methamphetamines. This information is interspersed throughout the record primarily in case notes. The record doesn't confirm or dismiss any of this; there appears to be no analysis of these qualities related to the mother's functioning or her effectiveness in role performance. In sum, this information was not used to inform practice or decision making.

Notably, the record contains no evidence that the father (Christopher Payne) was ever assessed despite disputes about who was best suited to care for the children. The record indicates that CPS (according to a statement by the father) encouraged the father to seek custody of the children. No information is contained in the record to justify how or why CPS made these judgments. (Interestingly, if this encouragement to the father did occur presumably CPS was of the belief that the mother was less suitable to care for the children, however, that was never stated, concluded or justified by the record.)

It should be noted that despite the focus on allegations and maltreatment, the record does not demonstrate sufficient information about those areas. The extent of maltreatment or lack there of is not effectively qualified. Circumstances that accompany the reported maltreatment are not documented. So, even though the concentration is on allegations and maltreatment, findings and decisions are not supported in the record because of the lack of information.

In 1997 the Adoption and Safe Families Act established the requirement that whenever a child is placed outside the home being investigated that the placement home – whether relative or foster – must be evaluated for safety. It is common practice to arrange for a family member – including a father separated from the child's home – to care for a child while an investigation proceeds such as occurred in one of the investigations in this case. However, in this case, the record doesn't indicate that a serious evaluation of the safety of the father's home was evaluated. The record indicates that the worker observed that the father was appropriate and able and more than willing to care for the children. This single recorded and important observation is not accompanied by information which justifies this judgment. A police report records that a supervisor stated that placing the children with the father was best for the children; that the father was acting in good faith and taking necessary steps with CPS; and that the father was cooperative while the

mother was not. These are important considerations but not substantial when determining the safety of a placement option.

The record doesn't justify decisions from beginning to 2007, in particular the series of investigations resulting in unsubstantiated findings and (apparent) conclusions that children were safe. While it is likely that workers involved in these decisions possessed more information about the people and circumstances in these cases than was recorded and while it is likely that workers and supervisors consulted on the decisions, the record does not reflect either of those possibilities. The record in all investigations contains a number of case note recordings which document dates, times and descriptions of the contacts usually in the form of process recording (i.e., he said; she said.), usually these case notes reflect acceptable response and level of effort. The case notes continue to record what is happening in the investigation; the case notes do not identify and elaborate on the family and functioning with respect to assessment; the case notes sometimes identify what seems to be crucial case information or factors related to individuals, but more likely than not such information remains unqualified. These case notes continue along until without explanation either a case note or copy of a letter to the family or both appear stating that the investigation is complete and the finding is unsubstantiated. In some instances, such as with this mother, the notification letter encourages the family or parent to seek services. Both records in this review do not contain a substantive documentation of all that is known about the family as a result of information collection; an analysis of that information; a conclusion about the information; and justification for the conclusion. It is not possible to know if the major problem here is one of record keeping and record construction or case practice and decision making or both.

2. Observation regarding strengths in case practice in the Payne Case

A review of observations of the Marsh/Williams case confirms the same areas of strengths in general with the Payne case. Work activity; level of effort associated with contact and follow up; attention to cases; interaction with cases; apparent and acceptable rapport with and respect for clients; and documentation of daily goings on in the case are obvious within the record.

3. Observations regarding areas for practice improvement in the Payne Case

- The family is not the center of attention. While this fatality does not specifically involve the mother, the case and record is primarily associated with her. In fact every investigation is focused on her. So, the record provides no confirming information and justification about the father as a source of concern or a source of protection.

- The mother's problems are serious, in particular using methamphetamines. These problems are never fully explored and judgments are not recorded concerning the effects of such conditions on her related to her capacity to care and protect. The responsibility for determining the use of drugs is left to her. She denies and avoids drug testing. CPS apparently does not work with the mother during investigation to establish the extent and seriousness of her functioning and behavior. The record implies almost a disconnect between the seriousness of the mother's condition and the existence of maltreatment; likelihood of maltreatment; and threats to child safety.

- CPS involvement with the father after he took (at least physical) custody of the children is not explained in the record. Early in the record the family situation was qualified as a custody dispute not a CPS matter. However, at least with the mother, CPS reports continued. The record indicates that the mother believed that CPS continued to have a case open with the

father after he had custody of the children. However, there is no recording showing regular or planned contact with the father. Later in the case a case aid visits the father but the record isn't clear about what the purpose of those visits were.

- A 12/6/06 investigation of the mother did not include any contact or assessment with the father, although the mother reported to the worker that the children were with their father. No analysis occurred concerning the situation of the children being with their father rather than their mother or the status of the father's home. No one saw those children at that investigation either. This is another example of what appears in the record as such a narrow consideration during investigation that the family system and family network are not part of information collection – even if only as collateral sources.

- The recordings in the beginning investigations provide no substantive information about the father but seem to indicate that workers were experiencing him as functioning appropriately. While no assessment information occurs on the father as the case progresses, there is also no information that suggests any concerns about the father or any evidence that his behavior is deteriorating. At the agency's last contact with the father on 2/21/2006, a case aide records nothing that would indicate having observed concerning behavior or situations. CPS notified both parents through letters dated 3/1/2006 that the CPS case was being closed. The father was arrested on 3/1/2007 and admitted to using heroin and abusing his children. The record in its entirety does not provide information that would reveal and explain; rule in or rule out; or serve as indication that the father's behavior that resulted in the children's deaths was pre-existing, developed over a long time; or was in development at the last CPS contact; or developed in those five months. What the record does indicate but doesn't fully explore or explain is that throughout most of the

case the father demonstrated motivation to have his two children with him.

4. Observations on case documentation (both cases)

- The Marsh record contains volumes of clinical notes concerned with non CPS generated activity, including information on educational and mental health services. It contains a significant number of administrative forms and case notes that primarily record day to day, week to week activity; family life circumstances and events and case communication. Many of the documents have the same information cut and pasted. There are duplicates of material. Everything is filed by date in chronological order and in some instances by categories. The essential family information to guide decision making and intervention is dispersed throughout the record. The value of what occurs over time with the family is difficult to capture and use to inform practice decisions. Simply stated, the record doesn't seem like a very good tool for driving and supporting practice and decision making.

- Whether it is a result of record keeping or whether it is a characteristic of actual casework, there is a quality of CPS behavior reflected in the records that results in assessment of each new CPS report without factoring in previous information or experience with the family.

- Structure and process for the case record is established by management. To be fair to CPS staff it's important to acknowledge that if a record is to affect their thinking and approach to intervention, information within the record must be accessible; readily usable; and in a format that contributes to work they must do, how they continually make decisions and regulate their work.

5. Comparison of Casework to State of the Art

There are two ways to think about the state of the art. The state of the art can represent the most common way CPS practice and decision making occur – good or bad. Alternatively, the state of the art can represent what popularly is know as best practice – the way practice and decision making should occur. Both are legitimate perspectives.

The work contained in this record is actually very similar to what workers do across the country. Related to the most common way of doing CPS, one could say that this work is rather consistent with the state of the art of actual practice. The casework is characterized by high activity (level of effort) and low case movement (static state.) The focus, almost obsession with allegations, is quite common; it is easier for workers to understand; and it is easier for workers to examine when in the field with the family. The absence of more robust information collection is absolutely apparent everywhere. This is related to agency expectations but just as much related to the intent and abilities of the worker to engage family members in productive interviews.

The approach to safety apparent in this case is also common within current national practice. Workers remain confused about differences of maltreatment, risk of maltreatment and safety; they have difficulty interpreting what they are seeing in order to identify and understand safety threats; and they tend to consider safety assessment more as a required agency event rather than a way of thinking.

What is evident in this record concerning the disconnect between assessment and case planning is consistent with prominent CFSR findings. So it would have been a surprise to find case plans grounded by effective case assessments and in particular assessments of adult functioning.

The leadership/governing aspect of intervention mentioned earlier is not common within the state of the art. What is more common is what is seen in this case regarding reactive case management; the lack of systematic

intervention; disconnects between functions – namely investigation and ongoing CPS; reliance on community providers to figure out what should be done in cases; and lack of clarity about who the agency serves and toward what end. Most of what can be observed in this case about case plans and service provision is consistent with what is common within the current national practice. Case plans are not individualized; are poorly crafted; do not effectively involve the client; are not owned by the client; and are driven by a problem-service paradigm (e.g., a violent parent equals go to anger management classes.) This review didn't examine supervision. It was noted that evidence in the record indicates the presence and activity of the supervisors. What is also evident, however, is that supervision did not alter the direction or substance of the case. There is no evidence that indicates that work improved because of supervision.

Supervision apparently had little effect with altering important casework practice and decision making. In some ways it can be concluded that supervision endorsed the approach. That is common within the state of the art of CPS practice. Notably, the kind of practice and decision making that endured in this case endures in similar fashion cases everywhere today.

The other standard for state of the art is best practice – the way practice and decision making should be. Almost all of that which represents best practice standards has existed for a long time and continues to be refined in areas like safety intervention. These observations have indicated several areas of questionable practice and decision making. These would all be viewed as not comparing favorably with the standard of best practices within the state of the art. To meet this standard practice and decision making would have had to be more purposeful; highly directed toward specific case outcomes; regulated in a highly professional process of assessment and problem resolution; guided by sufficient, pertinent information about the family. Intervention would have been driven by outcome rather than characterized by the day to day process of family life and case activity. Concepts and practices would have

been correctly based on worker understanding and would have contributed to case movement. Intervention would have been highly individualized directed at what must change and associated with judging parental capacity and willingness to provide care and protection to children. To meet the best practice standard community involvement would have been as obvious as in this case but (through collaboration) would have been charted and directed by CPS. Workers and supervisors would have accepted the responsibility for the safety of the children and applying a process that would result in the mother's changed behavior or, alternatively, some other acceptable, permanent option for the children. The work in this case fell short of the standard for best practice.

The two cases reviewed are remarkably the same with respect to how the records reveal the quality of investigations. There are two observations about the Payne case (consistent with the Marsh/Williams case) related to comparison to the state of the art. The most consistent problem evident in the quality of investigations across the country today is insufficient information to make and support effective decision making. Several case studies within the past 5 years indicate that workers either do not collect and/or do not record the necessary abundance of pertinent, relevant information related to the family being investigated. Central to this problem is the concentration on allegations at the expense of a wider view of family life and individual and family functioning. However, there is something in this record related to the allegation focus which is different when compared to other states. This record contains less quantity and quality related to information about allegations and maltreatment and therefore less justification for those areas. In particular, it is common for investigations focused on maltreatment to assess both parents which did not occur in this case.

Record keeping has been mentioned often in these observations. Normally and traditionally requirements and practices have resulted in workers documenting information collected during investigation; an analysis of the

information and their conclusions; justification for their conclusions in one place within the record at the completion of the investigation. Traditionally this has been referred to as an investigation summary and it occurred in narrative form. Within the past decade or more forms, instruments, and even automated templates have achieved the same objective. So, the state of the art and best practice is for records to communicate in a single and direct manner (a single place) the results of an investigation and information which explains and justifies the results. As has been mentioned in various ways in these observations, such is not the record keeping format or approach in these cases.

6. Recommendations based on case reviews

- Require fuller, more robust investigations that go well beyond the allegation to explore relevant areas of the family system and family functioning in order to inform safety decision making and case planning.

- Clarify perspectives and practice about how much weight can be given to allegations Develop worker thinking and assessment to view allegations and maltreatment as symptomatic of a struggling or failing family so that those serve as windows into examining the functioning of families and family members.

- Safety concepts and safety intervention can be the central driving influence in investigations and throughout the involvement with families which demands worker mastery in applied methods and decision making.

- Require structured safety assessment applied in each investigation and occurring for certain at the conclusion of the investigation to assure that fuller information is factored in.

- Convey certainty about who CPS seeks to serve and what the reasons are for CPS continued involvement in a family; consider and integrate into

practice the importance of the caregiver as the focus of CPS attention and intervention.

- Collect and analyze information about the adults in a family; assess aspects of the adult functioning and specific aspects of their parenting and caregiver protective capacities as a basis for case plans.

- Apply a systematic CPS intervention approach which follows a step by step process directed at specific objectives and regulated by timeliness.
- Incorporate a fuller appreciation for dynamics of unsafe environments that avoids focusing on a single child; that avoids being tied to allegations; that promotes routinely considering the status of the unsafe-safe environment into practice throughout the life of the case.

- Employ a case planning process that engages parents in taking responsibility for their change; involves them in developing plans that are their plans; assure that the plans are based on the reason for CPS involvement; assure that plans meet case planning criteria (such as measurable goals, etc.).

- Attempt a paradigm shift from case manager as orchestrating community services to the person responsible to implement a process that addresses safety and what must change; as the person who guides a step by step change approach; as the person who directs community providers and services related to what must change; as proactive rather than reactive.

- Create an approach to record keeping that improves the effectiveness of the record as a tool to influence and guide practice and decision making while still meeting accountability and storage needs; consider how to assure that information is factored into decision making.

- Overall, improve the diligence, rigor and quality of investigations (at least as reflected accurately in documentation). The point here is if practice is

better than the record reflects, it is important to do something about record keeping and documentation.

- Direct the investigation to gather family system's information that all family members are assessed whether they are reported as perpetrators or not. Consider the importance of all caregivers as the focus of CPS attention and intervention.

- Collect and analyze information about the adults in a family; assess aspects of the adults and their parenting as a basis for case plans.

- Establish the record as a dynamic case practice tool.

- Finally, a serious area of need apparent in the records is the identification, description or mention of serious individual client behavior or concerns or serious family situations without weighing the significance, judging the meaning; and acknowledging the seriousness with respect to implications for CPS action and decisions.

7. Closing

What I've observed about these two cases appears to be consistent with findings in Arizona case reviews conducted by others in our organization. Although time did not allow for other than brief discussion, Theresa Costello, MA and Emily Hutchinson, MSSW expressed having observed in case reviews they have completed much of what is contained here. Notably, they mentioned insufficient information collection; allegation orientation; failure to analyze and interpret serious case information; and difficulty in using the record as a practice tool (i.e., format, structure, etc.) The NRCCPS case review report authored by Emily Hutchinson is an important source of information for comparison to observations about the cases in this review. Finally, it is noted that it is my understanding that much of what has been observed here has already been acknowledged by the Department and corrective planning and action have been occurring for some time now. These actions, in general, direct implementation of a guided approach to safety

assessment, strengths and risk assessment and case planning that gives purpose and meaning to information, identifies information necessary to make sound decisions and provides a template format to guide information collection and integrate case information in a meaningful and logical way. Arizona has invested significant time and effort into this process in order to improve practice across the state.

Child Welfare Practice in Arizona: How Recent Improvements Address Recommendations of Wayne Holder, MSW, Executive Director, ACTION for Child Protection: *Arizona Case Review* Report.

1. **Require fuller, more robust investigations that go well beyond the allegation to explore relevant areas of the family system and family functioning in order to inform safety decision-making and case planning.**

   Agency Response: Beginning with the January 2003 appointment of the Governor's Commission for Child Protective Services Reform through the January 2007 implementation of a comprehensive child safety assessment/case planning process, child welfare practice in Arizona is being transformed from an "incident-based" approach – focused on current allegations and family situations – to a more holistic assessment of family dynamics and case planning for measureable outcomes related to child safety and overall family well-being. The revised, comprehensive child safety assessment/case planning process – implemented between January and June 2007 – guides case managers in the collection and analysis of information about the family and its dynamics. It also guides the case manager's decision-making based on that information, including building a case plan with the family that is focused on specific outcomes.

   The revised, comprehensive child safety assessment/case planning process was developed in consultation with the National Resource Center for Child Protective Services and the National Resource Center for Family-Centered Practice and Permanency Planning to: reflect current best practice; improve integration of the child safety assessment, family risk assessment, and case planning processes; improve documentation; improve critical decision-making; and, enhance clinical supervision. Both the process and the policies place significant emphasis upon the completion of comprehensive assessments that go beyond the report allegations.

   Specifically, the revised, comprehensive child safety assessment/case planning process and corresponding child welfare policies:

   - Move practice from "incident" based investigation to a comprehensive assessment of child maltreatment and family strengths and needs.
   - Set a standard for and create statewide uniformity in the practice for child safety and risk assessment and case planning.
   - Create a process for assessment and case planning, not a form to complete. This process:
     - Creates a "template" that includes all required action steps from receipt of a report for investigation to case closure.
     - Guides the collection, analysis and application of information during the investigation of child maltreatment.
     - Informs decision-making about child safety and risks assessments and case planning.

- Involves families in the design of case plans that include specific, measureable behaviors that must change so that the home environment can be safe for the child.
- Places all documentation in one place, reflective of the decision-making process.
- And, improves clinical supervision of the assessment and case planning process.

Clinical supervision is a key strategy to better ensuring the implementation of best practice; it provides a systematic means for CPS supervisors to review the quality of information collected by their staff and based upon the information gathered, the quality of critical-decisions being made. Requirements for clinical supervision were integrated into the revised, comprehensive child safety assessment/case planning process to ensure supervisory review at critical decision points throughout the life of the case.

Division leadership recognized the urgency in improving investigations, family assessment and case planning, and implemented a paper version of the revised, comprehensive child safety assessment/case planning process *10 months ahead of schedule* instead of waiting for the automated version, which will be implemented in November 2007.

Statewide specialized training on family engagement, assessment of family needs, child safety assessment, assessment of strengths and risks, and behavioral-based case planning was provided during the implementation process to all staff. Follow-up training, as needed, is being provided on an ongoing basis, including on-site technical assistance. Training for newly hired CPS specialists is provided by the Division of Children, Youth and Families (DCYF) Child Welfare Training Institute. As planned, the automated version of the revised, comprehensive child safety assessment/case planning process will be launched next month.

Quality assurance is a key component to ensuring that actual child welfare practice is meeting the newly established best practice standards. Within 60 days after implementation of the revised, comprehensive child safety assessment/case planning process, the Division and the National Resource Center consultants evaluated its implementation in each DCYF District and provided technical assistance as necessary to District staff. Based upon the results of these evaluations, CPS supervisors held individual meetings with their staff to advise them on areas of practice that were assessed as strengths and areas requiring improvement. The initial reviews of all Districts will conclude this month. District management teams are also reviewing cases on an ongoing basis to ensure proper implementation of the revised, comprehensive child safety assessment/case planning process and child welfare policies and to provide opportunities to identify and provide additional training to staff, including CPS supervisors. In addition, a random sample of cases will be reviewed on an ongoing basis by DCYF practice improvement specialists to rate the use of the

process and identify areas requiring the implementation of practice improvement plans.

2. **Clarify perspectives and practice about how much weight can be given to allegations. Develop worker thinking and assessment to view allegations and maltreatment as symptomatic of a struggling or failing family so that those serve as windows into examining the functioning of families and family members.**

   Agency Response: As part of the implementation of the revised, comprehensive child safety assessment/case planning process, concepts that further developed CPS specialists' critical thinking and assessment skills were incorporated into the initial training provided to staff between January and June 2007. At the same time, these concepts also were incorporated into the initial training the new CPS specialists receive in the Child Welfare Training Institute. In addition, the Division's Child Welfare Policy Manual was amended in September 2007 to include Best Practice Tips on comprehensive assessment of the family and assessing protective capacities of all caregivers.

3. **Safety concepts and safety intervention can be the central driving influence in investigations and throughout the involvement with families which demands worker mastery in applied methods and decision-making.**

   Agency Response: As indicated in the response to Recommendation 2, training to achieve mastery of these applied methods and decision-making is included in the training provided to all staff when the revised, comprehensive child safety assessment/case planning process was implemented, and has become part of the Child Welfare Training Institute's curriculum for newly hired CPS specialists. In addition, CPS supervisors work with their staff on a daily basis to master these concepts.

   The Child Safety Assessment (CSA) identifies the potential for present and/or foreseeable danger of serious harm (i.e. safety concerns) to a child and when safety factors are identified, requires CPS specialists to develop and implement a safety plan for the child, to control or immediately resolve or reduce the potential of harm.

   The safety assessment identifies 17 safety factors that must be explored by CPS Specialists related to family systems and family functioning, including factors extending beyond the initial CPS report allegations. CPS specialists, in consultation with their CPS supervisors, make safety decisions about each child. When the completed safety assessment identifies unsafe conditions, CPS specialists develop a Safety Plan with the family, identifying what actions will be taken to ensure their child's safety, who is responsible for each of the actions, and how the Safety Plan will be monitored. When a Safety Plan cannot be adequately identified and the child cannot live safely in the home with services provided to

the family, CPS specialists identify other safe alternatives for the child's placement including placement with relatives or out-of-home care.

In addition to the child safety assessment, CPS specialists are required to complete a Strengths and Risk Assessment (SRA) of the caretakers within 45 days of the case opening (prior to investigation closure). The comprehensive assessment requires staff to assess and document five critical areas of family functioning along with a comprehensive review of 17 risk factors that are associated with child maltreatment. The five sections are: Baseline Level of Risk; Child Vulnerability; Caregiver Characteristics; Family, Social and Economic Factors; and, Overall Level of Risk.

Completion of the strengths and risk assessment assists CPS specialists in determining if the case should remain open and in developing an individualized and relevant case plan or aftercare services. CPS specialists also must complete and document safety re-assessments whenever evidence or family circumstances suggest an increase in levels of risk and/or prior to CPS supervisors' approval when considering whether to close an ongoing case. Case closures are based upon the determination that the identified risks have been sufficiently mitigated to the extent that the likelihood of future maltreatment in the absence of CPS services and monitoring is low and to determine an appropriate aftercare plan.

4. **Require structured safety assessment applied in each investigation and occurring for certain at the conclusion of the investigation to assure that fuller information is factored in.**

Agency Response: As part of the Division's revised, comprehensive child safety assessment/case planning process implemented in January 2007, the Division now requires that CPS specialists complete a child safety assessment for every CPS report investigated and prior to closure of the investigation. Please see the response to Recommendation 3 for additional information.

5. **Convey certainty about who CPS seeks to serve and what the reasons are for CPS continued involvement in a family; consider and integrate into practice the importance of the caregiver as the focus of CPS attention and intervention.**

Agency Response: CPS serves children by ensuring their continued safety and by helping their families make the changes necessary to make their homes safe for children. As indicated earlier, the Division's revised, comprehensive child safety assessment/case planning process includes comprehensive assessment of all caregivers' capabilities, and engages families in designing a case plan that identifies the specific, measureable caregiver behaviors that must change in order for the child to be safe. Please see responses to Recommendations 1 and 3 for additional information.

6. **Collect and analyze information about the adults in a family; assess aspects of the adult functioning and specific aspects of their parenting and caregiver protective capacities as a basis for case plans.**

   Agency Response: As previously discussed, as part of the revised, comprehensive child safety assessment/case planning process, adult functioning, parenting, and each caretaker's ability to protect the child are determined and based upon the results of these assessments, are incorporated into the case planning process.

   The case planning process has been revised to reflect caretaker behaviors that must change versus solely focusing on tasks that must be completed. The case plan is built on a foundation of family strengths and involves the family members in its design. The success-based, behavioral case planning process describes the behaviors that need to occur to improve the family's situation, implements a case plan that supports these changes in behavior, and is frequently evaluated to assess whether the behavior changes are occurring. The process also includes a case plan review that allows for frequent analysis of child safety, risk issues and the efficacy of services in changing behaviors that brought the family to the attention of the child welfare system. Progress in meeting case plan goals and objectives are analyzed on an ongoing basis. Please see responses to Recommendations 1 and 3 for additional information.

7. **Apply a systematic CPS intervention approach which follows a step-by-step process directed at specific objectives and regulated by timeliness.**

   Agency Response: Please see the responses to Recommendations 1 and 6.

8. **Incorporate a fuller appreciation for dynamics of unsafe environments that avoids focusing on a single child; that avoids being tied to allegations; that promotes routinely considering the status of the unsafe-safe environment into practice throughout the life of the case.**

   Agency Response: Please see the responses to Recommendations 1, 3 and 6 for additional information.

9. **Employ a case planning process that engages parents in taking responsibility for their change; involves them in developing plans that are their plans; assures that the plans are based on the reason for CPS involvement; assures that plans meet case planning criteria (such as measurable goals, etc.).**

   Agency Response: Family engagement includes commitment of the family, relatives, and significant others in decision-making and supports to the family. Family engagement strategies were incorporated within the Child Welfare

Training Institute's training for newly hired CPS specialists in 2005 and is provided on an on-going basis as specialized training for CPS specialists. In addition, the DCYF Child Welfare Policy Manual includes best practice tips on engaging families. In 2006, the Division began further embedding family engagement in child welfare practice through the statewide implementation of the Annie E. Casey Foundation's Family to Family strategies, which includes family engagement as an overarching means to improve outcomes for children and families. Family to Family has been implemented in Maricopa County and is currently being implemented in Pima County. After receiving some technical assistance from the Casey Foundation in September 2007, the rest of the Division's districts statewide are finalizing plans and timelines for implementing Family to Family in their communities. As indicated earlier, the Division's revised, comprehensive child safety assessment/case planning process reflects caretaker behaviors that must change versus solely focusing on tasks that must be completed. Please see Recommendation 6 for additional information.

10. **Attempt a paradigm shift from case manager as orchestrating community services to the person responsible to implement a process that addresses safety and what must change; as the person who guides a step-by-step change approach; as the person who directs community providers and services related to what must change; as proactive rather than reactive.**

    Agency Response: The Division's revised, comprehensive child safety assessment/case planning process reinforces the concept of the CPS specialist being the primary person responsible for the assessment and identification of safety and risk factors, including the primary person responsible for guiding the change approach identified through the case plan. Coordination of services includes close collaboration with contracted service providers to assure services are supportive of the case plan requirements. Please see the responses to Recommendations 1, 3 and 6 for additional information.

11. **Create an approach to record-keeping that improves the effectiveness of the record as a tool to influence and guide practice and decision-making while still meeting accountability and storage needs; consider how to assure that information is factored into decision-making.**

    Agency Response: The Division's revised, comprehensive child safety assessment/case planning process provides a mechanism for documenting in one place the information gathered during the course of CPS' work with the family. Instead of being focused solely on proving or disproving the allegations in the report, the enhanced process guides case managers in the collection and analysis of information about the family and its dynamics. It also guides and documents the case manager's decision-making based on that information, including building a case plan with the family that is focused on specific outcomes. Currently in paper format, the process is on-schedule to be fully automated in

November 2007, further enhancing the accessibility and storage of the information for future decision-making.

12. **Overall, improve the diligence, rigor and quality of investigations (at least as reflected accurately in the documentation). The point here is if practice better than the record reflects, it is important to do something about record keeping and documentation.**

    Agency Response: As previously mentioned, the Division's revised, comprehensive child safety assessment/case planning process guides case managers in the collection and analysis of information about the family and its dynamics. It also guides the case manager's decision-making based on that information, including building a case plan with the family that is focused on specific outcomes. The process provides a mechanism for documenting in one place the information gathered during the course of CPS' work with the family. Please see responses to Recommendations 1, 3, 6 and 11 for additional information.

13. **Direct the investigation to gather family system's information that all family members are assessed whether they are reported as perpetrators or not. Consider the importance of all caregivers as the focus of CPS attention and intervention.**

    Agency Response: As previously mentioned, the Division's revised, comprehensive child safety assessment/case planning process guides case managers in the collection and analysis of information about the family and its dynamics, including a determination of adult functioning, parenting, and each caretaker's ability to protect the child. All of these factors are incorporated into the case planning process. Please see responses to Recommendations 1, 6 and 9 for additional information.

14. **Collect and analyze information about the adults in a family; assess aspects of the adults and their parenting as a basis for case plans.**

    Agency Response: This is a repetition of Recommendation 6; please see the agency's response to that recommendation.

15. **Establish the record as a dynamic case practice tool.**

    Agency Response: The Division's revised, comprehensive child safety assessment/case planning process guides the collection and analysis of family system and family functioning information to inform decision-making throughout the life of a case. It provides for CPS supervisors' review and approval of information gathered and decisions made by CPS specialists. The process will be fully automated next month and revised as new enhancements are identified. Please see the responses to Recommendations 1, 3, 6, and 11 for additional information.

16. **Finally, a serious area of need apparent in the records is the identification, description or mention of serious individual client behavior or concerns or serious family situations without weighing the significance, judging the meaning; and acknowledging the seriousness with respect to implications for CPS action and decisions.**

Agency Response: Identifying and including descriptive information related to serious client behavior and concerns and the identification of serious client behavior has been incorporated within the revised, comprehensive child safety assessment/case planning process and child welfare policies. CPS specialists are required to collect a foundation of information that addresses six key questions:

1. If maltreatment did occur, what is the extent of the maltreatment?
2. What are the circumstances surrounding the maltreatment?
3. How does the child function on a daily basis?
4. What are the disciplinary approaches and typical context used by the caregiver?
5. What are the overall, pervasive parenting practices used by the caregiver?
6. How does the caregiver function with respect to daily life management and general adaptation including substance abuse and mental health functioning?

For issues identified as concerns, CPS Specialists must also evaluate child safety threats according to the following criteria:

1. Duration
2. Consistency
3. Pervasiveness
4. Influence
5. Continuance

This foundation for the collection of information better ensures the identification of clients with serious behaviors or concerns and the assessment of serious family situations that may place a child at-risk of maltreatment.